Connecticut Department of Children and Families

AUTHORIZATION: HELD BED

DCF-2157
8/19 (Rev.)

Agency Name:		Program Name:			Provider ID#:
Agency Address (No. and Street)		City:		State:	Zip:
For TFC Placements: Caregiver LAST Name:		Caregiver FIRST Name:			Provider ID #:
CHILD IDENTIFYING DATA					
Child LAST Name:		Child FIRST Name:		Child DOB:	Child ID#:
Placement Date:	Date of Temporary Living Arrangement:			Type of Temporary Living Arrangement:	
DCF Area Office:					
SW LAST Name:	SW FIRST name:		SW E-mail:		SW Phone:
SWS LAST Name:	SWS FIRST Name:		SWS E-mail:		SWS Phone:
PS LAST Name:	PS FIRST Name:		PS E-mail:		PS Phone:

PLEASE COMPLETE THE SECTION BELOW THAT APPLIES

BED TO BE HELD NO MORE THAN 7 DAYS INITALLY – Social Work Supervisor Authorization

Initial dates for which HELD BED is requested Beginning: Ending:	Total Number of days:	X Rate:	TOTAL Amount
SW Signature:			Date

BED TO BE HELD AN ADDITIONAL 21 DAYS FOR HOSPITALIZATION OR FOR SPECIAL CIRCUMSTANCE – Program Supervisor Authorization

Initial dates for which HELD BED is requested Beginning: Ending:	Total Number of days:	X Rate:	TOTAL Amount
Program Supervisor Signature:			Date

BED TO BE HELD OVER A TOTAL OF 28 DAYS FOR HOSPITALIZATION OR FOR SPECIAL CIRCUMSTANCE – Office Director Authorization
(CFTM is Required is extending beyond 45 days)

Initial dates for which HELD BED is requested Beginning: Ending:	Total Number of days:	X Rate:	TOTAL Amount
Office Director Signature:			Date

RETURN OF CHILD TO AGENCY

Date the Child returned to the agency:	Agency Signature:	Date Signed:

SUBMIT COMPLETED FORM TO CHILD WELFARE ACCOUNTING: ChildWelfareAccounting@ct.gov (FAX: 860-560-7064)